



State of Utah

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Date: May 9, 2022

Commissioner Wade Hollingshead
Beaver County Commission
105 E. Center St.
Beaver, Utah 84716


Dear Commissioner Hollingshead:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of the contracted Local Authority, Southwest Behavioral Health Center; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,


Brent Kelsey (May 9, 2022 18:34 MDT)

Brent Kelsey
Interim Division Director

Enclosure

cc: Jerry Taylor, Garfield County Commission
Gil Almquist, Washington County Commission
Andy Gant, Kane County Commission
Paul Cozzens, Iron County Commission
Michael Deal, Southwest Behavioral Health



Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contract # A03083

Review Date: March 22, 2022

Final Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Southwest Behavioral Health Center (also referred to in this report as SBHC or the Center) on March 22, 2022. Due to current DSAMH policy, the audit was conducted remotely. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	7
<i>Combined Mental Health Program</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	10-11
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Use Disorders Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Use Disorders Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 None	20-21

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Southwest Behavioral Health Center (SBHC) remotely due to current DSAMH policy. The Governance and Fiscal Oversight section of the review was conducted on March 22, 2022 by Kelly Ovard Administrative Services, Auditor IV.

The site visit was conducted remotely with SBHC as the Local Authority and contracted service provider for Garfield, Iron, Kane, Washington and Beaver Counties. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided.

As part of the site visit, SBHC provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

There is a current and valid contract in place between the Division and the Local Authority. SBHC met its obligation of matching a required percentage of State funding.

As required by the Local Authority, SBHC received a single audit for the year ending June 30th, 2021 and submitted it to the Federal Audit Clearinghouse. The CPA firm Hafen Buckner Everett & Graff, PC performed the Center's audit and issued a report dated December 6, 2021. The auditor issued an unmodified opinion, stating that the financial statements present fairly, in all material aspects, the financial position of SBHC. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. The Block Grant for Prevention & Treatment of Substance Abuse & Mental Health Services and The Block Grant for Community Mental Health Services was identified as a major program and was selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2021 Audit:

No findings for FY21

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

- 1) There were no *Conflict of Interest forms* uploaded for the subcontractors. The DSAMH Contract Article 1:13 states that: The LA shall implement a written policy that requires its representatives, including employees, **subcontractors**, and volunteers, to: 1) submit a conflict of interest Disclosure Statement upon hire and annually thereafter.

County's Response and Corrective Action Plan:

Action Plan: While individual staff hired by our Subcontractors have signed Conflict of Interest Statements, we had not yet included the State's COI statement in our contract packet for Subcontractors. We are now adding that into our DocuSign process and will have each Subcontracting entity sign the COI.

Timeline for compliance: Between now and the end of the fiscal year.

Person responsible for action plan: Mike Deal will ensure the COI form is created, then Jennifer Gray will add to DocuSign and send out to all Subcontracting entities.

Tracked at DSAMH by: Kelly Ovard

FY22 Recommendations:

- 1) *Conflict of Interest and Dual Employment forms* were not signed by the designated staff. It was noted in the audit meeting that they are only signed when there is a conflict. It is recommended that the forms are completed with the required staff signatures or a new signature line is added for HR staff to sign/initial that it has been reviewed where no conflict/dual employment exists
- 2) *The Southwest Mental Health emergency plan* was reviewed by Nichole Cunha and Geri Jardine, as part of the site visit. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that these suggestions are reviewed and the emergency plan is updated accordingly.

FY22 Division Comments:

- 1) Thank you to Mike Deal and his staff for the timely upload of documents and coordination of the audit.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Combined Mental Health Programs

The Division of Substance Abuse and Mental Health (DSAMH) Mental Health Team conducted its annual monitoring review at Southwest Behavioral Health Center (SBHC) on March 22, 2022. Due to the current DSAMH policy, the annual monitoring review was held virtually. Duplicate findings for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

Findings for Fiscal Year 2022 Audit

FY22 Division Comments:

- 1) *Youth-in-Transition (YIT)*: SBHC has expanded their YIT program to improve coordination with adult programming. Movement to the telehealth platform has resulted in more services for the frontier programs they serve. As an example, clients do not need to wait until there are enough participants to form an in-person group at a service site. Instead, groups are created more readily by including YIT from different counties.
- 2) *Access to Care*: SBHC has a robust approach to contracting with community providers to better serve their clients. Through contracting, clients are able to access additional services in their community to meet their clinical needs. As Washington County is one of the faster growing counties in Utah, SBHC approach to a contract model should allow for more access to mental health services in their catchment area. DSAMH encourages SBHC to continue to explore creative opportunities to meet the growing needs of their communities.
- 3) *Mobile Crisis Outreach (MCOT) and Stabilization and Mobile Response (SMR) Services*: The SBHC MCOT and SMR teams are able to provide outreach to crisis situations across all counties in their catchment area. Team members are scheduled to alternate between SMR and MCOT services, ensuring ongoing coverage and preventing staff burnout from responding to crises after hours. SBHC is also sending the first group of employees to certified crisis response training.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review Southwest Behavioral Health Center (SBHC) on March 22, 2022. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Mindy Leonard, Program Manager; Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY22 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Peer Support, and compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

- 1) *Youth Outcome Questionnaire (YOQ)*: Of the ten charts reviewed, four charts had no evidence of the YOQ being used as an intervention with ongoing services. One chart did not use the YOQ as an intervention, however they had an assessment only and no ongoing services. This is an improvement from FY20 in which seven charts did not use the YOQ as in intervention. Two charts reviewed did not demonstrate administration of the YOQ "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives which is a noted improvement from FY20. While it is recognized that COVID-19 and the move to telehealth may have impacted administration of the YOQ, DSAMH encourages SBHC to review processes to ensure that the YOQ is administered and utilized as a tool in treatment.

This item has not been resolved; see FY22 Deficiency #1.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

- 1) *Youth Outcome Questionnaire (YOQ)*: Of the ten charts reviewed, four did not demonstrate use of the YOQ as part of the clinical intervention. There was no change in use from the prior

year. Division Directives state “*Data from the Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (YOQ) shall be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children aged five and under).*” Use of the YOQ is a useful indicator in treatment and can be used to identify reduction of clinical symptoms. SBHC should review with clinical teams the impact of using the YOQ measures as part of the clinical treatment process for youth and families.

County’s Response and Corrective Action Plan:

Action Plan: SBHC will address with each MH Youth provider the need to review the YOQ findings with the client in session. This will be addressed by the Program Manager in Team Meetings and also the Records Specialists will review for improvement.

Timeline for compliance: This will begin no later than the end of the fiscal year and will be monitored throughout the coming year.

Person responsible for action plan: Shari Lindsey will address the Program Managers and task them to address staff. Wendy King will task the Records Specialists with this corrective action over the course of the year.

Tracked at DSAMH by: Mindy Leonard

FY22 Recommendations:

- 1) *Family Peer Support Services (FPSS):* SBHC leadership expressed an understanding of the value of FPSS to support youth and families in finding success. The FY21 scorecard indicates a decrease in the number of youth and families served through this service (FY20/24, FY21/9). SBHC reported this decrease was likely due to staff turnover and the need to pivot the responsibilities of FPSS to support other youth programming in the agency. It is recommended that SBHC target this decrease and develop a plan to ensure that families have access to this service.

SBHC recently hired a peer support coordinator. SBHC is encouraged to utilize this role to explore opportunities to expand FPSS services and increase the number of certified FPSS at their agency. In the chart review of FPSS it was noted that much of the FPSS was provided directly to the youth, not to the family. SBHC is encouraged to review the role of FPSS and work with DSAMH, if needed, to ensure that parents are receiving this service on behalf of their family, and that youth are provided the services when appropriate, after age 16. Additionally, with the closure of Allies with Families, DSAMH recommends that SBHC have a plan to train, coach and certify FPSSs at their agency to provide family peer support directly to families.

FY22 Division Comments:

- 1) *Family Engagement:* In recognition of the need for better parent engagement to support family system work and client care, SBHC's youth team is developing a way to more effectively provide education for parents on their child's mental health needs. This process includes providing more psychoeducation and pathways for parental engagement in treatment. DSAMH looks forward to learning more about how this targeted approach changes outcomes for youth and families.
- 2) *Community Collaboration:* DSAMH notes that they have heard positive feedback from multiple stakeholders in the community about the collaboration and engagement of the children's team to support the youth in the community. Stakeholders have reported that SBHC has a responsiveness and collaborative approach to help find creative solutions to meet the needs of both their clients but also other youth in the community.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult team conducted its annual monitoring remotely for Southwest Behavioral Health Center on March 22, 2022. The monitoring team was unable to do an in person monitoring visit due to current DSAMH policy. The monitoring team consisted of Pam Bennett, Program Administrator; Mindy Leonard, Program Manager; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: record reviews and questions completed by the clinical director, visits with SBHC staff, Clubhouse, and Multiple staffings with adult mental health. The monitoring team reviewed the Fiscal Year 2022 audit; statistics, including the Mental Health Scorecard; and Area Plans; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2021 Audit

FY21 Minor Non-compliance Issues:

- 1) *Administration and Use of the Outcome Questionnaire (OQ)*: The frequency in which the OQ is being administered is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. Six of the ten charts that were reviewed lacked evidence that the OQ was being administered every 30 days. In nine of ten charts reviewed, there was no evidence that the OQ was being used as a clinical tool. Division Directives require that the data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. Although the pandemic and movement to telehealth has impacted OQ administration statewide, this has been a finding in FY18, FY19 and FY20. SBHC implemented an extensive reporting and tracking plan to address this finding in FY20. DSAMH recommends that the plan continue to be implemented, particularly as improvements were seen in the Child, Youth, and Family Mental Health charts.

This item has been resolved and will not be a finding in the FY22 monitoring report. The OQs were administered within required timeframes, with evidence of the OQs in the client charts.

FY21 Deficiencies:

- 1) *Measurable Objectives*: The recovery plan objectives were not measurable within the charts. Division Directives state, "The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment." The current Utah Preferred Practice Guidelines state, "objectives are measurable, achievable and within a timeframe." Objectives in five of the ten chart reviews were vague and difficult to measure (e.g. "client will stand up for herself" and "manage symptoms"). The finding remains at a Deficiency as the FY20 plan to resolve the finding may have been impacted by the change in leadership (an integral part of the FY20 plan) and the pandemic.

This item is resolved and will not be a finding in the FY22. Measurable objectives were evident in all charts reviewed.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

None

FY22 Recommendations:

- 1) *Supported Employment/Individual Placement and Support:* The FY21 Adult Mental Health Scorecard indicates a 46.2% decrease in supported employment numbers. It is likely that this is influenced by the pandemic and fewer individuals receiving services overall. DSAMH recommends that SBHC continue with efforts to ensure that individuals who are interested in supported employment services are able to access this evidence-based programming.

FY22 Division Comments:

- 1) *Diversion from Higher Levels of Care:* SBHC offers a wide array of services throughout their 5 county catchment area, with a focus on the expansion of Mobile Crisis Outreach Teams and a commitment to an adult receiving center, which continues to increase the diversion options for individuals in crisis. Appointments are scheduled prior to discharge from an inpatient stay with immediate follow-up if that appointment is missed. A case manager meets with clients at intake to identify needs related to continuity of care and social determinants of health, mitigating the risk of further decompensation.
- 2) *Cherished Families:* Cherished Families provides a comprehensive array of services to address social determinants of health, working with SBHC on treatment for individuals with polygamist backgrounds. A suicide coalition has been started in Hildale, in collaboration with the SBHC prevention team.
- 3) *Peer Support Services (PSS):* Heather Rydalch, Peer Support Program Manager, reviewed charts for adult PSS. The scorecard showed a decrease in PSS services by 1%. In FY21, the agency provided telehealth outreach during the pandemic. SBHC indicated that they have had some staffing challenges, and have hired a new PSS Coordinator to put together policies and procedures for PSS. SBHC is now able to provide certification PSS training for new peer support hires.

- 4) *Participant Feedback:* Tracy Johnson, Wraparound and Family Peer Support Program Administrator, met with 5 individuals at the Elev8 day program. All individuals expressed that they like treatment, believe it is helpful, and are engaged and making progress. They like the program and the opportunity to attend, and have supportive therapists and staff who help them. One individual said he had moved from the Salt Lake area and liked the individualized attention he received and how much people, including staff, care about his progress and needs. In particular, they like the chess club, the activities available at the program, and the opportunity to have a support animal. Individuals expressed that they love the garden spot and they are planning and getting it ready. They like watching March Madness with others and enjoy the health walk daily. They feel supported to give their input, and staff/therapists help them make a plan to reach their goals. No one holds them back. “When I reach my goals and feel success, I feel happy and proud.”

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 23, 2022. The review was completed remotely due to current DSAMH policy. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

- 1) The *Eliminating Alcohol Sales to Youth (EASY) checks* decreased from 129 to 42 checks from FY19 to FY20 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year.

The Eliminating Alcohol Sales to Youth (EASY) checks decreased from 42 to 24 checks from FY20 to FY21 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year.

This issue has not been resolved, which will be discussed in recommendation #1 below.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

None

FY22 Recommendations:

- 1) The *Eliminating Alcohol Sales to Youth (EASY) checks* decreased from 42 to 24 checks from FY20 to FY21 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year. It is

recommended that SBHC work with law enforcement and other community members to increase the number of EASY compliance checks.

FY22 Division Comments:

- 1) *Creek Valley Prevention Coalition:* The Creek Valley Prevention Coalition includes Hildale and Apple Valley (Utah), and Colorado City, Cane Beds, and Centennial Park (Arizona). This coalition is going strong and is in Phase III of the Communities that Care (CTC) model. They have been doing some projects which have benefited the Hildale community. For example, they are getting ready to roll out a partnership with their grocery store which is located in Arizona through a Parents Empowered Marketing Campaign. They are planning to put large banners on the walls and floor covering which has messaging regarding the dangers of alcohol and underage drinking. Since this grocery store is located in Arizona, they sell a variety of types of alcohol and have a balcony upstairs with a bar that is used for parties and meeting events. These efforts are part of a broader project in the community for training and education with parents. One of the gaps in the Hildale community that stood out in the community assessment was the lack of knowledge that parents have regarding underage drinking. The Creek Valley Prevention Coalition is providing training through the Guiding Good Choices program and has implemented positive action programming in Arizona and Utah. They have also been successful in encouraging parents and kids to participate in these programs. For example, they are offering incentives to parents that are participating in Guiding Good Choices or the Strengthening Families Program. The Creek Valley Prevention Coalition is also preparing to do messaging campaigns regarding prescription drugs (Know your Script Campaign) which will be located on the doctor's office doors and front desk.
- 2) *Prevention Marketing:* SBHC shared that marketing depends on the program and strategy. For example, school-based programs are marketed through school counselors and administrators, and sometimes are promoted through classroom presentations to students. Law enforcement strategies are promoted through coalition meetings, key leader meetings, and training with law enforcement. Each community approaches marketing differently, in accordance with cultural competence research. This year, SBHC purchased news spots with ABC4 News to highlight and market specific programs. There were a total of 12 news spots that were done at Southwest last year, which were also posted on their social media sites. The following news spots are examples of the news spots that were aired this past year: (1) Hope For Tomorrow and Youth Coalitions and (2) Clearing the Vapor Program. These news spots were aired in various areas of the county where there has been a considerable amount of interaction from the community.
- 3) *Data Driven Services:* SBHC monitors substance use and alcohol trends in various communities to implement effective evidence-based prevention services. For example, the drinking levels are different in different communities. SBHC recently looked at the data for

Parowan where parents have limited knowledge on the impact of underage drinking. SBHC has been doing a parent night at the Parowan High School to review some of the Student Health and and Risk Prevention (SHARP) Survey data results with them. In Parowan, alcohol rates have increased dramatically from 2019 to 2021. In 2019, the 30-day alcohol use rate was around 4% at their Parowan Cone Site, which increased to 6% in 2021. SBHC reported that youth are primarily accessing alcohol in Parowan at parties or hang outs. The other way that youth are accessing alcohol is through adults over the age of 21. There was also an increase in the number of kids that have consumed alcohol in their home with their parent's permission. The alcohol use in Parowan is 20% higher than the aggregate of all five of the counties in Southwest. SBHC has been able to provide effective evidence-based services for their community through evaluating data, risk and protective factors.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Southwest Behavioral Health on March 23, 2022. The audit was completed remotely due to current DSAMH policy. The review focused on compliance with State and Federal law, DSAMH contract requirements, and DSAMH Directives. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to Drug Court, Justice Reinvestment Initiative (JRI) and contract requirements were evaluated by a review of policies and procedures, clinical records and through interviews with Southwest Behavioral staff. Treatment schedules, policies, and other documentation were also reviewed. The Utah Substance Use Disorder Treatment Outcomes Measures Scorecard results were reviewed with staff. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data. Finally, additional data was reviewed for Opiate Use for Washington, Iron, Garfield, Kane, and Beaver Counties.

Follow-up from Fiscal Year 2021 Audit

FY21 Minor Non-compliance Issues:

- 1) The Treatment Outcomes Scorecard shows the following:
 - a) The percent of **clients that were arrested from admission to discharge** moved from 35.2% to 18.3% from FY19 to FY20 respectively, which does not meet Division Directives.

The percent of **clients that were arrested from admission to discharge** moved from 18.3% to 17.4% from FY21 to FY21 respectively, which does not meet Division Directives.

This issue has not been resolved, which will be addressed in Recommendation #1 below.

- b) The number of **clients involved in social recovery support** decreased from 29.1% to 22.6% from FY19 to FY20 respectively, which does not meet Division Directives.

The number of **clients involved in social recovery support** decreased from 22.6% to 20.5% from FY20 to FY21 respectively, which does not meet Division Directives.

This issue has not been resolved, which will be addressed in Recommendation #2 below.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

1) The Treatment Episode Data Set (TEDS) shows that:

- a) The number of **old open admissions (charts that should be closed)** was 5.6%, which does not meet Division Directives. There should be less than 4% of charts that can be open at any given time.

County's Response and Corrective Action Plan:

Action Plan: SBHC has generally done very well with this issue. However, we will follow up with the SUD teams to ensure that each client is discharged as they leave the program. David Eves will work with the Records staff and Program Managers to make sure this process occurs.

Timeline for compliance: This is an on-going process. Staff involved will be reminded of this process immediately.

Person responsible for action plan: Both Rylee Munns, Program Manager for SUD, and David Eves, Data Manager.

Tracked at DSAMH by: Rebecca King

1) The Client Satisfaction Surveys shows:

- a) 8.5% of **Youth Satisfaction Surveys** were collected, which does not meet Division Directives.
- b) 9.0% of **Youth (Family) Satisfaction Surveys** were collected, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: We will continue to attempt to meet the State requirement. We will look for incentives for staff to improve the gathering process. Executive will address our Program Management team as well.

Timeline for compliance: We will start working with our Intake and front desk staff immediately in preparation for the next period of completion. For FY22, this time period for completion has already passed.

Person responsible for action plan: Debbie Fisher (over Intake) and David Eves (Data Manager) will monitor.

Tracked at DSAMH by: Rebecca King

FY22 Deficiencies:

None

FY22 Recommendations:

- 1) *The Treatment Episode Data Set (TEDS) shows that:*
 - a) The percent of **clients that were arrested from admission to discharge** moved from 18.3% to 17.4% from FY20 to FY21 respectively, which does not meet Division Directives.
 - b) The number of **clients involved in social recovery support** decreased from 22.6% to 20.5% from FY20 to FY21 respectively, which does not meet Division Directives.

FY22 Division Comments:

- 1) *Residential Treatment:* SBHC provides residential treatment services for their five counties. **The Horizon House East and Horizon House West** offer gender specific residential treatment, available at two separate locations. Both locations are licensed as 45+ day substance use disorder facilities. The treatment offered combines group and individual therapy, education classes, anger management, communication skill building and relapse prevention. The residential portion of treatment (Phase I) is followed up by Phases II and III which are outpatient services which are provided in each of the five Southwest Counties. **Desert Haven** is a residential support facility for women in the five county area. The facility is licensed for up to 7-10 adult women and up to 6-9 children (ages 8 and under) belonging to the women. The women in the program attend substance abuse day treatment at the main St. George Office Complex, while day care services are provided to their children. The treatment offered combines group and individual therapy, education classes, anger management, communication skill building, parenting skills, life skills education, and relapse prevention.
- 2) *Comprehensive and Quality Services:* SBHC has dedicated and effective treatment teams and disciplines which are comprehensive in scope, including specialized teams such as: Case Management, Women's and Children's Residential (Desert Haven), Mobile Crisis Outreach Team (MCOT) / Stabilization and Mobile Response (SMR), Supported Living (Mt. View House, Dixie View and duplexes), three Drug Court Teams, Mental Health Court Team,

Trained Peer Support Specialists in all programs, and Supported Employment. SBHC also places an emphasis on the complete training of staff in evidence-based practices, which includes incentives for ongoing participation in consultation/supervision. Evidence-based practices SBHC has recently focused on including: Eye Movement and Desensitization Reprocessing (EMDR), Seeking Safety, Moral Reconciliation Therapy (MRT) and Medication Assisted Treatment.

- 3) *Community Partnerships and Innovative Services:* SBHC invests itself in strong Partnerships, including; Family HealthCare (FQHC), Beechtree Lab, Cherish Families, Law Enforcement (including the provision of Crisis Intervention Team (CIT) training), The Intermountain 'Alliance', Drug Court, Mental Health Court, and Switchpoint (Homeless shelter) to name a few. SBHC also has contracted with a robust panel of service providers (the largest in Utah outside of Salt Lake County); including inpatient programs, SUD residential programs, Intensive Outpatient (IOP) programs, private outpatient therapists and prescribers and trainers. SBHC is innovative and developed programs like a Commitment Board, an acute hospital liaison position, and engaged in the early adoption of mobile response and quick development of a full array of telehealth services during COVID pandemic.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.


Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Southwest Behavioral Health Center and for the professional manner in which they participated in this review.

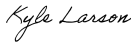
If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118.

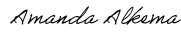
The Division of Substance Abuse and Mental Health

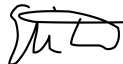
Prepared by:


Kelly Ovard  Date 05/09/2022
Administrative Services, Auditor IV

Approved by:

Kyle Larson  Date 05/09/2022
Administrative Services Director

Amanda Alkema  Date 05/10/2022
Assistant Division Director

Eric Tadehara  Date 05/09/2022
Assistant Division Director

Brent Kelsey  Date 05/09/2022
Division Director

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY22

Name of Local Authority: Southwest Behavioral Care Center

Date: March 15, 2022

Reviewed by: Nichole Cunha, LCSW
Geri Jardine

<i>Compliance Ratings</i>				
Y = Yes, the Contractor is in compliance with the requirements. P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance. N = No, the Contractor is not in compliance with the requirements.				
Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Confirmation of the plan's official status (i.e., signature page, date approved)		X		Need confirmation of the plan's official status (ie.,
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)	X			
Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)			X	Need place to identify changes to the plan, made by whom, and date of change
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan	X			
Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.				
List of essential functions and essential staff positions	X			
Identify continuity of leadership and orders of succession	X			
Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)	X			

Communication procedures with staff, clients' families, the State and community	X			
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Planning Step				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)				
<p>The planning team has identified requirements for disaster planning for Residential/Housing services including:</p> <ul style="list-style-type: none"> • Engineering maintenance • Housekeeping services • Food services • Pharmacy services • Transportation services • Medical records (recovery and maintenance) • Evacuation procedures • Isolation/Quarantine procedures • Maintenance of required staffing ratios • Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic 	X			

DSAMH is happy to provide technical assistance.











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Final Audit Report

2022-05-10

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